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ABSTRACT

Although studies indicate that as many as 22 percent of women have been raped, few of these women seek help immediately after the rape. Most rape victims experience a postrape distress response which may not be resolved for some victims. Long-term symptom patterns include fear/avoidance responses, affective constriction, disturbances of self-esteem/self-efficacy, and sexual dysfunction. The understanding of long-range psychological problems is complicated by temporal distance between trauma and aftereffects, the interaction of trauma with the victim's coping process, and life changes. Because of culturally supported myths about rape such as the woman bearing responsibility for the rape, a victim is more likely to accommodate the rape than to resolve it. Most treatment studies have focused on only the first year postrape. A stress inoculation treatment package for nonrecent rape victims who are demonstrating phobic fears has been developed which includes didactic, coping skills, cognitive, and facing fears components. Procedures for treatment of nonrecent rape victims include assessing spontaneous rape resolution; building a relationship with the client; addressing resistance; and fostering rape resolution through discussion of painful feelings, involvement of the social network, promotion of cognitive re-appraisal, restoration of self-efficacy, and treatment of target symptoms. Refinement in conceptual models of rape impact and resolution is needed. (ABL)

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Clinical Treatment of Nonrecent Rape: How Much Do We Know?

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Abstract

Recent prevalence studies have suggested that 13-22% of women have been raped at some point in their lives, but as few as 4% of them sought professional assistance immediately. Even when administered immediately postrape, however, psychotherapy has not been shown to improve the outcome of treated rape victims over that achieved by minimal contact alone. Studies of nonrecent victims indicate that postrape aftereffects are persistent and that many entered psychotherapy eventually, often years after the actual assault. These observations suggest that the primary role of psychotherapy in the treatment of rape victims is the identification and handling of chronic, posttraumatic responses to a nonrecent experience. It is concluded that most of the existing literature on the aftereffects and treatment of rape treatment addresses the immediate traumatic responses only. The present paper is a discussion of the processes through which victims accomodate to sexual assault and the long-term impact of these efforts. Then, assessment and treatment procedures for nonrecent victims are suggested.

Clinical Treatment of Nonrecent Rape: How Much Do We Know?

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Recent prevalence studies have indicated that between 13% and 22% of women have been raped at some point in their lives (Koss, 1983; Koss & Oros, 1982; Russell, 1984). Rape victims rarely seek help or utilize assistance immediately postassault. For example:

-- A recent study of college student rape victims indicated that only 4% of the women had obtained victim assistance services from a rape crisis center and another 4% had sought professional counseling. Fewer than half of these women told anyone at all about their assault or even labeled themselves as rape victims (Koss,1983; in press).

-- Among adult victims three months postrape, less than half of the women who were judged to need treatment agreed to accept psychotherapy (Kilpatrick, Veronen, & Resick, 1979a).

--Only a quarter of victims who entered an immediate postrape treatment program completed a 14 hour course of therapy (Frank & Stewart, 1983).

The reluctance of rape victims to utilize formal treatment immediately postassault does not seem alter the course of their recovery however. For example, Kilpatrick, Veronen, & Resick (1979a) developed a brief behavioral intervention procedure of 4-6 sessions. This treatment consisted of a didactic component (e.g. presenting a rationale for the development of rape related fears and conveying the contribution of culturally supported rape myths to self-blame) and a coping skills component (e.g. muscle relaxation, diaphramatic breathing, guided self-dialogue, and encouragement to confront feared situations). No significant treatment effects were found on outcome measures between two groups of recent rape victims, one of which received treatment while the other received minimal contact only. Resick (1983) concluded that "rape victims are frequently unwilling to receive any type of therapeutic intervention within the first few months after the assault. They (and their families) often express the hope that if they don't talk about the assault and try not to think about it, they will forget it and recover" (p. 131).

Unfortunately, evidence from long-term follow-up studies with rape victims suggests that spontaneous recovery doesn't characterize the majority of victims. More than 40% of rape victims reported continued sexual difficulties, restricted going out, suspiciousness, fear of being alone, and depression 1 to 2 1/2 years postassault (Nadelson, Notman, Jackson, & Gornick, 1982). Problems in long- sexual functioning (e.g. Becker, Skinner, Abel & Treacy, 1982; Burgess &

Holmstrom, 1979a) and in marital adjustment also have been reported (Miller, Williams, & Bernstein, 1982). Only 25% of rape victims were found to be free of significant symptoms on standard psychological tests one year after the assault (Kilpatrick, Veronen, & Resick, 1979b). More than one year after the rape, victims still scored one standard deviation above nonvictimed women on a fear survey. Burgess and Holmstrom (1979a) interviewed rape victims four to six years after sexual assault and asked them if they "felt back to normal, that is, the way you felt prior to the rape." The responses indicated that 37% of the victims had felt recovered within months; 37% felt recovered only after several years, and 26% did not feel recovered. Thus, it is not surprising that among one sample of women raped 1-16 years previously, 48% of stated that they eventually had to seek psychotherapy for help with rape related concerns (Ellis, Atkeson, & Calhoun, 1979). This paper is a review of clinical and empirical work on the treatment of the nonrecent rape victims.

The Aftereffects of Rape

For ethical and humane reasons, no empirical studies have been attempted of rape victims within hours of the assault. Likewise, practical considerations have made it difficult to keep a sample of victims intact during followup periods longer than one year. Consequently, most prospective empirical studies of the symptommatic responses to rape have focused on the time period between one month and one year postrape. Extensive reviews of this material are available elsewhere (e.g. Holmes & Lawrence, 1983; Ellis, 1983).

What is known is that most vicitms experience an immediate

postrape distress response, which for some victims, fails to resolve and develops into a chronic, though heterogeneous symptom pattern that may persist for variable length of time (Ellis, 1983). The core features of these long-term symptom patterns appear to be a set of fear/avoidance responses, affective constriction, disturbances of self-esteem/self-efficacy, and sexual dysfunction. A number of factors may modify the intensity of a victim's response to rape including: characteristics of the crime (McCahill, Meyer, & Fischman, 1979; Frank & Stewart, 1983), locus of control (Janoff-Bulman, 1979), coping ability (Burgess & Holmstrom, 1979a), life stress (Ruch, Chandler, & Harter, 1980), personality variables and social network (Atkeson, Calhoun, Resick, & Ellis, 1982), and developmental stage of the victim (Notman & Nadelson, 1976). No isomorphic relationship between trauma and symptom has been observed. However, the nature of the interactive effects and why some victims develop more chronic patterns is not yet know.

A primary need is to develop a better understanding of the nature of the long range psychological problems associated with sexual assault. This should be a high priority for research but it is an area fraught with problems. The establishment of causal links is complicated by the temporal distance between trauma and long-term aftereffects, the inability of victims themselves to connect early trauma with current functioning, and the relatively high percentage of multiply victimized clients. A further obstacle to study of long-term aftereffects is that the long-term postrape clinical picture is not due simply to the earlier sexual assault. Rather, the pattern

is determined by the trauma interacting with the effects of the coping processes adopted by the victim. A final difficulty is that the long range impact of rape may involve changes not evident in the immediate postrape picture, changes that emerge only after the response of the social network and postrape life changes have been assimilated by the victim.

Accomodation Versus Resolution of Rape Trauma

Trauma is dissipated as a result of a reintegration process (Pasewark & Albers, 1972) that includes a series of cognitive, affective, and behavioral changes. Finkel (1975) has emphasized the role of cognitive reappraisal in the reintegration process whereby the initial interpretation of an event is replaced by an evaluation that emphasizes new attributes including the discovered ability to cope, adapt, learn, grow, and become self-reliant; and produces a greater sense of strength, depth, maturity, sensitivity, honesty, and self-confidence.

These changes seem most unlikely to occur spontaneously in rape victims because many do not disclose their sexual assault to anyone and because all must contend with a culture in which socially transmitted myths about rape support a belief in the woman's responsibility for rape (Burt, 1980). Rather than supporting a redefinition of rape as "bad luck," these cultural myths may reinforce feelings of unworthiness in a raped woman. Thus, the clinician is unlikely to see cognitive reappraisal and resolution of rape but is likely to see an accomodation to it. The pernicious consequences of the accomodation process for child sexual assault victims has

recently been described (Summitt, 1983). Met with disbelief and rejection, the child victim assumes responsibility for the sexual victimizations or simply denies the reality of them. In so doing, the child victim is forced into a psychological position of "self-blame, self-hate, alienation, and revictimization" (Summit, 1983, p. 177). The accomodation process can lead to a decrease in the complexity of self-schema, can enhance vulnerability to future stressful negative events, and may impair the overall functioning of victims (Linville, 1982). Because the highest rates of rape are recorded in the 17-21 year old age group, many victims are unlikely to have reached a mature adult level of cognitive abilities that might mitigate the effects of sexual assault. The impact of rape may be magnified by adolescent egocentricism whereby individuals believe that what they are thinking is what everyone is thinking, and by their belief that they are in front of an imaginary audience who is evaluating them.

Even the adult victim, burdened with the myths of female responsibility for sexual outcome, will find it difficult to obtain validation of the reality of her status as a victim. Denied the opportunity to develop a positive reinterpretation of her experience, the victim must assimilate degradation and helplessness into her behavior and world view. To the extent that a victim sees herself as damaged and unworthy, she may become compromised her ability to be powerful and to affirm her dignity. Symptomatically, the clinical picture may vary from a constricted, fear dominated, withdrawn client to a client who acts out her inability to affirm her dignity by being repetitively involved in abusive relationships.

Empirical Evaluations of Treatment Effectiveness

Because few empirical studies have attempted to describe the aftereffects of rape beyond a one year period, it is not surprising that most treatment studies have focused only on those symptoms that have been observed immediately postrape. (Extensive reviews of this material can be found in Ellis, 1983; Holmes & Lawrence, 1983; and Resick, 1983) . In fact, the bulk of the published literature on rape treatment evaluation consists of behavioral case studies where a single intervention is directed at a focused symptom (e.g. Becker & Abel, 1981; Blanchard & Abel, 1976; Wolff, 1977).

There are large scale outcome studies of rape treatment, but these have also involved behavioral treatment of the victim immediately postassault (e.g. Kilpatrick, Veronen, & Resick, 1979b; Turner & Frank, 1981). However, a stress innoculation treatment package has been developed for nonrecent rape victims (3 or more months postassault) who demonstrate phobic fears and avoidance(Veronen & Kilpatrick, 1983). Treatment procedures include a didactic component (i.e. a rationale for the development of rape-related fears and a discussion of the contribution of culturally supported rape myths to self-blame), a coping skills component (i.e. muscle relaxation, diaphramatic breathing, guided self-dialogue, encouragement to confront feared situations, role playing, and covert modeling), a cognitive component (i.e. thought stopping for intrusive thoughts, guided self-dialogue to replace negative self-statements), and specific homework assignments which require graded practice in facing target fears. Nonrecent rape victims who received this

treatment package were compared to nonvictims who received assessments only. While preliminary findings were positive (Veronen & Kilpatrick, 1982), formal results have not yet been published.

There appears to be a mismatch in the design of many rape treatment studies between therapy goals, treatment procedures, and outcome measures. For example, outcome measures frequently have focused exclusively on target symptom reduction. Although theoretical discussions of rape treatment, even those based on a behavioral perspective, highlight the importance of cognitive changes, there has been a lack of attention in outcome studies to the specification and measurement of cognitive changes that would be reflective of rape assimilation and resolution.

In addition, therapy durations in most studies were brief (4-10 sessions) and were administered immediately postassault. These interventions may be too early and too short to alter the fundamental process of rape resolution. They do not seem to take into account the magnitude of changes that have to occur to resolve a trauma. Particularily with remote victims who have lived silently with their experience for years, treatment effects may be demonstrable only after the therapeutic process has guided the victim into positive life experiences that reinforce a changed cognitive appraisal of the sexual assault. Such changes require time. While a large number of treatment sessions may not be needed, it may be prudent to space them out in time and arrange for a longer period of followup posttherapy before the final verdict on therapy effectiveness is rendered.

Clinical Considerations with the Nonrecent Rape Victim

Consider the following client who illustrates a typical clinical picture of a nonrecent rape victim:

> A 40 year old woman came to treatment because she was experiencing debilitating distress following a burglary of her home. At intake she describes a history of dysphoria and a repetitive pattern of unsatisfying relationships with men. Later, after many treatment sessions devoted to these issues, she describes being abandoned during a time of crisis by a man with whom she was in love. Immediately after the breakup, her ex-lover's boyfriend broke into her apartment and forced her to have sex. With tears streaming down her face, she wonders what impact this experience has had on her life.

While few writers have addressed the unique treatment considerations posed by this type of rape victim, valuable contributions have been made by Forman (1980) who discusses the assessment of spontaneous rape resolution; Burgess & Holmstrom (1979b) who describe a dynamic brief psychotherapy for the treatment of silent rape reaction (i.e. acute rape trauma triggered by an event symbolic of the earlier assault), and a number of writers who have proposed focused interventions for use with specific rape related target symptoms (e.g. Veronen & Kilpatrick, 1983).

We are concerned, however, that no single source describes comprehensively the clinical considerations in the treatment of nonrecent rape. We are particularily concerned that some behavioral treatment approaches, shown to be ineffective with victims immediately postassault, would be inappropriate to nonrecent victims without

supplementation by attention to the victim's needs for support and validation as well as procedures specifically directed at the cognitive resolution of rape. Therefore, from published papers and our own clinical experience, we have distilled the following procedures for the treatment of the nonrecent rape victim:

Assess Spontaneous Rape Resolution

Unresolved sexual trauma occurs when a woman is raped, shares little or no information about her experience with others, and consequently is unable to settle her reactions to the experience (Burgess & Holmstrom, 1979). Undoubtedly, there are instances where a woman gives a history of sexual assault that is not a primary causal factor in her presenting symptom picture. Therefore, Foreman (1983) describes several criteria that the clinician can consider to determine whether intensive psychotherapeutic work needs to be directed towards a client's remote assault experience. The presence of any of the following factors suggests unresolved sexual trauma: inability to discuss the rape openly without glibness or overreacting, persistent postrape symptoms that were not present or not as severe prerape, negative meanings ascribed to the rape experience, postrape deterioration in the victim's social support system or total avoidance of men, or overaction to a disagreeable but relatively minor sexual molestation.

Build a Relationship and Address Resistances

As always, treatment begins with the establishment of a therapeutic relationship with the client. Particularly in cases where sexual assault occurred at an extremely early age, there may be

considerable interference with the normal development of trust and the ability to relate to others. Techniques beyond those geared toward basic relationship building should be held in abeyance until the clinician observes the signs of a working relationship.

Foster Rape Resolution

The following procedures may require the bulk of therapeutic time. They are designed to modify the negative impact of a victim's attempts to accomodate her self-concept to the sexual assault. Rape resolution is promoted by the following four clinical procedures:

Discuss painful feelings. In the context of a supportive therapeutic relationship that is nonblaming and validates the client's experience, discussion of painful feelings regarding a past sexual assault may result in a "corrective emotional experience." Talking about a painful experience helps to strip it of its distressing potential and to return a sense of control to the vicitm. Often, however, the constraints that have kept the memories suppressed for so long are still apparent to the clinician. The victim who has been unable to share her experience with anyone frequently requires assistance to facilitate remembering and verbalizing the painful feelings connected with her rape. Support and reassurance are important to bringing out out painful memories (Burgess & Holmstrom, 1979b). In some cases victims may desire to discuss their feelings but various factors (e.g. repression, suppression, effects of time, young age at time of assault) may render them unable to remember much about the experience. Techniques such as deep breathing, muscle relaxation, free association, prompted recall, or hypnosis may assist

the victim to recall her experience.

Involve the social network. Resolution of a rape experience involves sharing it with significant others if the victim has not done so previously. Telling others may not be easy if the victim has hidden her secret for months or years. It may be helpful to discuss in advance whom to share the information with, how to present the experience to them, and what their reaction is likely to be. Victims may be encouraged to write their experiences down in diaries or letters as a step toward verbalizing them. When possible, a guided confrontation with the perpetrator can be very therapeutic. Involvement in a support group for incest or rape victims may be helpful to expand the social support availab le to the victim.

Promote Cognitive Re-Appraisal

Rape victims are no different from nonvictimized women in the extent to which they subscribe to myths about rape (Koss, in press). Many misperceptions exist about rape and it is helpful to learn what the victim thinks about the cause of her rape, the degree to which she feels responsible, and the longterm consequences she expects as a result. Techniques aimed at symptom reduction may ultimately fail unless thoughts and perceptions are modified. Burgess & Holmstrom (1979a) described several styles of thinking about rape that occurred spontaneously and seemed to be associated with recovery. They included suppression ("I don't think about it at night"), minimalization ("Compared to what a young girl would experience after a rape, my experience wasn't bad"), rationalization ("He was a sick man who needed help and it was just a one in a million chance that he

broke into my house"), and dramatization (i.e. repeatedly expressing the memories of the experiency and thereby dissipating the anxiety associated with it.)

Veronen & Kilpatrick (1982) suggest three ways in which rape can be assimilated as a positive event: as a consciousness raising experience ("I wasn't much of a feminist before my rape but it kind of crystallized for me the way women are treated in our society"), as a life appreciation lesson ("During the rape I said to myself, 'If I come out of this alive, there's alot of things I'm going to change in my life and I'll be grateful for every minute of every day I live'"), and as a challenge to overcome ("I've always been a strong person I realize that now that I'm a survivor").

Therapeutic work on a victim's cognitive appraisal of her experience begins with the clinician eliciting her attitudes and beliefs regarding the rape. Beliefs that are adaptive are suported and reinforced, maladaptive cognitions, those that operate to maintain symptoms (e.g. "I know I'll never be normal after this," "Sex will never have meaning for me again," "That shows you how bad my judgement about men is"), are handled therapeutically . Therapeutic handling of maladaptive cognitions involves tactfully challenging them on the basis of their factual accuracy or the logic of their conclusions (e.g. "It's true that your dress was unusual, but does every woman who dresses punk deserve to be raped?") The goal is to assist the victim to reformulate her appraisal of her experience into terms that allow her to put the rape behind her and get on with her life. Such a reappraisal does not minimize rape, but aims to guide the victim to

positively assimilate rape into her picture of who she is, how she got that way, and where she is going from here.

Restore Self-Efficacy. We have hypothesized that the process of accomodation to rape can result in lowered self-esteem (i.e. "I'm a bad person") and self-efficacy (I'm weak, people take advantage of me"). Burgess and Holmstrom (1979b) observe that rape often disrupts important need satisfaction. A sexual assault may threaten needs to be cared about, to be secure, to trust, to be in control, and to achieve. The individual personality of a rape victim dictates the needs that are most impacted by rape.

Support and reassurance regarding the client's legitimate status as a victim are helpful to reducing guilt and self-blame and restoring self-esteem. The clinician also can suggest concrete steps outside of therapy that begin to restore a victim's self-efficacy. For example, the victim with strong needs to be cared about may believe that rape has lead important people to reject her. She may benefit by a referral to a support group led by recovered rape victims who can reach out and care for victims still struggling with their experience. The victim with a high need to achieve may benefit from encouragement to take training in rape counseling and eventually serving as a victim advocate. Through these types of adjunctive therapeutic experiences, low self-esteem and a lost sense of self-efficacy are addressed.

Treat Target Symptoms

As a consequence of successful rape assimilation, the victim may become able to look at her experience in a different light and conduct her future relationships on the basis of changed perceptions.

In instances where presenting symptoms are not severe, significant clinical improvement can be secured by the resolution of the assault experience alone without the use of further techniques.

However, when symptoms fail to resolve as a result of work on assimilation, specific treatment techniques focused on target symptoms are needed. Veronen and Kilpatrick (1983) present an excellent description of techniques to treat fear and avoidance. The treatment of rape related depression is addressed by Frank and Stewart (1983). Becker and Skinner (1983) describe the treatment of sexual dysfunction subsequent to sexual assault. The persistence of serious problems in a rape victim's established intimate relationships usually dictates conjoint sessions with her partner. To date no clinical literature addresses treatment techniques geared to the specific impact of rape on an established relationship.

Conclusions

In conclusion, the answer to the question about treatment of rape victims that we posed in the title, "How much do we know?," is "Too little." As public and professional consciousness is raised about the widespread prevalence of sexual violence, more women from the large pool of rapeed women may define themselves as victims and seek psychotherapeutic treatment. Already, clinicians are experiencing an increasing number of victims of childhood sexual assault who are seeking treatment subsequent to the extensive media coverage devoted to this topic recently. Because of the shock that immediately follows rape appears to preclude a commitment to treatment, the bulk of victims seen in psychotherapy have been assaulted months to years

earlier. We have observed that the long-term impact of rape and the clinical treatment of the nonrecent victim are not well addressed in existing literature. Our cardinal intent has been to call for refinement in the conceptual models of rape impact and resolution. In this way the vitality of the field can be sustained and new growth in our ability to help victims may result.

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